Print Form

# Medical Claim form

CAS
Consolidated Admin Services

P.O. Box 1513
Cabot, AR 72023
Phone: 501-941-5956
Fax: 877-641-5956
info@consolidatedadmin.com
www.consolidatedadmin.com

Date

Employer

SSN

First Name

Last Name:

Address:

☐ Check here if new address

**Documentation/Receipts for each expense must be provided.**

**Please Itemize each expense on form provided, if you have more expenses than form allows please attach separate form.**

| Date of Service | Provider Name | Description of Service | Expense Amount |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Total Expense**

I certify that the statement and information on this claim form are accurate and true.
I also certify that I am claiming reimbursement for only eligible expenses incurred during the plan year and are for eligible participants.
I certify that these expenses have not been or will not be reimbursed from any other source.
I assume all liability for taxes and penalties out of any disallowed contribution/reimbursement

Signature:

Date:

Mail claims to: P.O. Box 1513, Cabot AR 72023; Fax claims to: 877-641-5956; or E-mail claims to: info@consolidatedadmin.com
For questions regarding your claims please call: 501-941-5956